DEPARTMENT OF HEALTH CARE SERVICES
BEHAVIORAL HEALTH STAKEHOLDER
ADVISORY COMMITTEE
July 10, 2019

MEETING SUMMARY

Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Sarah Arnquist, Beacon Health Options; Ken Berrick, Seneca Family of Agencies; Catherine Blakemore, Disability Rights California; Michelle Cabrera, County Behavioral Health Directors Association of California; John Connolly, Los Angeles County Department of Public Health; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI California; Vanessa Cuevas-Romero, Sacramento Native American Health Center; Alex Dodd, Aegis Treatment Centers; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Veronica Kelley, San Bernardino County; Jim Kooler, California Friday Night Live Partnership; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; Robert McCarron, California Psychiatric Association; Farrah McDaid Ting, California State Association of Counties; Frank Mecca, County Welfare Directors Association of California; Maggie Merritt, Steinberg Institute; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Jonathan Sherin, Department of Mental Health, County of Los Angeles; Chris Stoner-Mertz, California Alliance of Child and Family Services; Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation; Dean True, County Behavioral Health Directors Association/Shasta County Health and Human Services Agency; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, Department of Corrections and Rehabilitation.

Members Attending by Phone: Jennifer Sayles, Inland Empire Health Plan; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers.

Members Not Attending: Vitka Eisen, HealthRIGHT 360; Andrew Herring, California Bridge Program; Catherine Teare, California Health Care Foundation.

DHCS Attending: Jennifer Kent, Mari Cantwell, Brenda Grealish, Don Braeger, Norman Williams, Morgan Clair, Lindy Harrington.

Guests: Thomas Insel, Bobbie Wunsch, Diane Cummins.

Public in Attendance: 85 members of the public attended in person and there were 81 phone participants.

Welcome, Introductions and Purpose
Jennifer Kent, DHCS

Director Kent welcomed Behavioral Health Stakeholder Advisory (BH-SAC) members. She mentioned that there is a presentation about the full array of mental health programs available for review by members.
https://www.dhcs.ca.gov/services/Documents/CA-Public-MH-SUD-Services-Overview.pdf

Introduction of Thomas Insel, MD

Dr. Insel introduced his role by letting BH-SAC members know that his position, Mental Health Advisor, is advisory to Governor Newsom. The purpose is to think broadly about the behavioral health system and what it should look like. The appointment of a special advisor on mental health is a statement by the Administration about the high priority of this issue. Dr. Insel reported that in a recent Kaiser Family Foundation and California Health Care Foundation poll, the number one health care issue mentioned by respondents was access to behavioral health services.

Dr. Insel offered that this is a volunteer role with the Administration that is part of his position at the Steinberg Institute. Dr. Insel reported he has been traveling the state to listen to input and ideas about what is needed over the next 4, 8, 10 years and more. He reported that what he heard is distressing and hopeful at the same time.

- No one is happy with status quo: This is a time to examine how the waiver and other opportunities can make fundamental changes in the system to improve it.
- There are pockets of excellence, and inspiring, creative work in counties: There is much to be learned from urban and rural places about what works.
- Integration is the word he heard most often: All kinds of integration are mentioned frequently: integration of SMI and mild/moderate; county specialty care and managed care; county MH and substance use; mental health and physical health. And it is important to accomplish integration in a way that improves access and quality.
- Workforce: There are huge challenges to accomplish a workforce that is culturally competent and meets capacity.
- Financing: The flow of money is a huge topic and opportunity. It is critical to streamline.
- There is an appetite for leadership/governance from the state: This is about the state offering greater technical assistance and support to help everyone do better.

Orientation to BH-SAC
Bobbie Wunsch, Pacific Health Consulting Group
Slides available:
https://www.dhcs.ca.gov/services/Documents/BHSAC_Orientation_071019.pdf

Bobbie Wunsch offered background on the history and purpose of the BH-SAC. Almost 10 years ago, DHCS created the Stakeholder Advisory Committee (SAC) to advise on 1115 Medi-Cal waivers. Director Kent felt that, given the growing attention and importance of BH, it was important to create a separate group to advise on behavioral health. The BH-SAC discussion is intended to be focused at a system-wide and policy level to improve the BH system. The BH-SAC represents the consolidation of several groups meeting on

related topics. The purpose of the group is to offer input and ideas on a range of issues from each person's knowledge and experience. There will be materials available to prepare for each meeting ahead of time and a detailed summary prepared after each meeting. Appointments are made by the DHCS Director and there are no proxies. She reported there will be four meetings each year that will alternate morning and afternoon with the SAC meeting and members are encouraged to attend the SAC meeting as well. She said it is important to participate in person so that meetings are more effective, however there is a member phone line for each meeting. Input to agendas will be solicited about six weeks prior to each meeting and each meeting includes public comment. Finally, Ms. Wunsch encouraged members to take full advantage of this opportunity to work collaboratively with colleagues and DHCS.

Behavioral Health Financing
Diane Cummins, DOF
Director Kent introduced Diane Cummins from the Department of Finance to offer an overview of the history, context and financing of Mental Health (MH) services. This will provide members an understanding of the history of how behavioral health services have been provided and funded in California. It should serve as a foundation for future discussion of improvement and change.

- 1957: Short Doyle (SD) was enacted with state funding for 50% of certain county MH services. Prior to that California was a hospital-driven system. The state hospital population was about 36,000.

- 1967: State hospital numbers were down to 18,800 and 41 counties operated SD programs.

- 1968: Lanterman-Petris-Short (LPS) Act created major changes to involuntary hospitalization. As part of this, the state began to fund 90% of certain local costs through SD and 58 county-operated programs. There were statewide services but not a uniform system of services because they developed locally in response to varying needs.

- Late 1980s-1990: In this period, new programs were enacted, including specialty programs such as children's system of care and a demonstration of adult integrated systems. There were also General Fund reductions. The state budget often drives policy change, and during this period, there were significantly lower state revenues.

- 1991-92: There was a budget shortfall that ultimately grew to $14 billion. To solve this problem, there was a proposal to eliminate discretionary programs, including community mental health and indigent services. Governor Wilson did not want to reduce them and asked Department of Finance to come up with an alternative. That led to a proposal for new taxes and realignment of programs. Realignment post-Proposition 13 changed the state-local relationship on governance, services and funding. California is one of 11 states where counties run programs on behalf of the state. Vehicle license fees and local sales taxes financed a MH Account with

$452 million for community MH, $210 million for state hospitals; $88 million for Institution for Mental Disease (IMD) costs.

- 1995: The Medi-Cal Mental Health Managed Carve out allowed counties to offer specialty mental health with realignment funding as match for federal funds. Maximizing Medi-Cal became the focus and less funding went to community MH programs.

- 1995: There was a lawsuit requiring Medi-Cal mandates, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, be funded. The focus was on categorical programs like mentally ill in jails.

- 2004: Prop 63 became a new source of funding for county mental health programs, ranging from $750 million - $2 billion to replace the categorical programs. Prop 63 is based on an allocation, not specific programs.

2011: Public Safety Realignment of $5.6 billion again changed county-state relationships. The biggest budget item was $1.12 billion transferred from the 1991 realignment to the 2011 realignment in the protected MH account.

Observations

- Counties operate mental health programs on behalf of the state and the programs operate under federal/state law and guidelines.
- Funds will remain local; 60% is vehicle-licensing fees and is constitutionally protected for counties. The remainder is sales tax revenue and must remain local or become subject to Prop 98 (meaning a reduction of 40-50% due to revenue going to education).
- Prop 30 is the constitutional amendment that protects the funding and it also requires the state to pay counties for any new requirements above the base of 2011 realignment, like foster care Continuum of Care.

Questions and Comments

Farrah McDaid Ting, California State Association of Counties: In the listing of all the funding sources for counties, can you offer more information on the 2011 realignment subaccounts for MH and BH?

Diane Cummins, *Department of Finance*: The $1.12 billion MH account funding was transferred from the 1991 realignment. The $1.5 billion for the BH subaccount was the rest of the county mental health managed care, EPSDT and Substance Use Disorder. It has roughly doubled, and some ask about the exact amount of money in each account. We know the original amount in the transfer by county, but it is flexible, so we don't know today's amount for each of those programs that were realigned.

Michelle Cabrera, County Behavioral Health Directors Association of California: Can you speak to the population distinctions covered under grants and other programs? Counties

have responsibilities for the Medi-Cal population but there are other populations that are required as well as discretionary populations.

Diane Cummins, *Department of Finance*: Medi-Cal is the largest population counties are required to serve and any funding source can be used for match. There are children covered under the EPSDT mandate through Medi-Cal. There are also many grant programs that counties can apply for and they may continue those programs after the grant using realignment. There is the medically indigent adult program that became part of ACA expansion and the state pays the non-federal share for this. A small piece is the LPS Act that purchases hospital beds. Overall, beds are down and there may or may not be all the needed programs in the community – like crisis residential and immediate acute care. It is important to look at gaps across the system in terms of beds and other services.

Kim Lewis, National Health Law Program: I want to clarify that EPSDT mandates remain in place regardless of the realignment. Even though this was included in realignment, the program and obligation to provide services is not capped.

Diane Cummins, *Department of Finance*: That is absolutely right. The realignment funds are for Medi-Cal entitlements. The account allows them to use different sources of money, like Prop 63, but does not change the obligation for entitlement programs.

Carmela Coyle, California Hospital Association: How do we, as a group not let budget policy drive us? What does it mean to say the sales tax must stay local? Does that preclude a make or buy decision?

Diane Cummins, *Department of Finance*: The DOF is always looking for how a change impacts the GF. Schools did lose approximately $2 billion through realignment because state revenue from sales tax went down by $5 billion and this changed the calculation for education. Prop 30 included taxes for schools to replace the money lost. The money is protected as to how it is used.

Carmela Coyle, California Hospital Association: Just to clarify, that wouldn’t preclude counties from aggregating it locally to spend it?

Diane Cummins, *Department of Finance*: The state collects this revenue. It must be used to fund programs in the account. There is a bright line about using the money for the allowable programs I mentioned. It can’t be used for law enforcement, for example.

Sarah Arnquist, Beacon Health Options: Have the statutory distributions ever changed since 1991 or 2011 realignment happened, based on population changes?

Diane Cummins, *Department of Finance*: Generally, realignment replaces money you would have gotten from the General Fund and then there is growth in the money over time. In 1991, some counties did not get an equitable amount on a per capita basis. There was a formula for counties to bring those up to equity, an allocation for distribution and

then a calculation for growth that counties negotiated. The growth allocation could be changed if counties wanted it, but changing it is very difficult.

Alex Dodd, Aegis Treatment Centers: You mentioned counties need to meet goals. Has the money been spent wisely?

Diane Cummins, *Department of Finance*: There are probably lots of opinions on that. I am of the opinion that counties do good work and know best what is needed. There is always room for improvement. The Legislature does watch these accounts and on occasion has questions about how or how much counties are spending. For example, some are watching Prop 63 to see whether it is being spent, however it is also a volatile source of funding that changes over time.

Linnea Koopmans, Local Health Plans of California: In thinking about the waiver renewal, how does realignment impact that discussion? What can or can't change in a 1915 waiver?

Diane Cummins, *Department of Finance*: I don't think you can know that yet, because it depends on what you want to accomplish in the waiver. Realignment is cited as being a barrier to changes, but it is not necessarily that restrictive. Change is easier at the local level than the state level.

Jennifer Kent, DHCS: Counties are able to voluntarily use their funding for the non-federal share as we have seen in the last two waivers with the public hospitals. Counties will need to voluntarily use their local funds; the state will need to partner and the money will flow by voluntarily putting up money from the county or state. Counties can aggregate their funding if they choose to.

Diane Cummins, *Department of Finance*: For example, AB109 does not prescribe what is to be delivered; it is fairly flexible. That is why there is an Executive Committee at the local level so there are discussions between law enforcement and health and human services about the best use of the funding.

Chris Stoner-Mertz, California Alliance of Child and Family Services: Have we done an analysis of the administrative costs associated with realignment? Such as audits and oversight, compared to when this was done as a state program?

Diane Cummins, *Department of Finance*: No, we haven't. Each county will be quite different. Counties are allowed to take overhead.

Jennifer Kent, DHCS: It is not calculated broadly. However, with the managed care rule, we added administrative money for compliance and would know the administrative cost for that piece.

Frank Mecca, County Welfare Directors Association of California: How would we know if have enough funding to do what we think is needed? It would be helpful to spend time

thinking this through because the nature of this entitlement is more vague than other entitlements. For example, we can calculate the cost of CalFresh because it is based purely on income – not medical need. Can we spend time thinking through what the required scope of benefits should be and what the costs are, who should be eligible for what; then use that to advise policy?

Jim Kooler, California Friday Night Live Partnership: We tend to talk services for response and less often about prevention. I would love to have that discussion in this group.

Jonathan Sherin, Department of Mental Health, County of Los Angeles: I am fascinated by the drop in state hospitals between 1957-67 and the SD investment in community mental health. What happened in jails and streets during that period? Is there data?

Steve Fields, Progress Foundation: When the aspirational movement came to treat in the community, which was a big part of that drop in state hospitals, Medicaid was also coming in at that time. Those dollars follow the individual. There was no consensus about what community mental health services should look like; what was needed in the move from hospital to community; and, whether clients would take up services. Community mental health was funding driven and the types of modalities offered were not expanded significantly until the rehab option was adopted. It took a while to see the consequences of all of this - filling jails and streets with mental health clients. It was the younger population we weren't prepared for because we set up our systems to serve those who had been institutionalized.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: What about co-occurring? Let's talk parity. What about substance use?

Steve Fields, Progress Foundation: You are right. That's an example of what we didn't prepare for. MH didn't serve substance use and substance use didn't serve MH disorders.

Waiver Planning for 1915b for Specialty Mental Health Services (SMHS) and 1115 Waiver for ODS
Jennifer Kent, Brenda Grealish, and Lindy Harrington, DHCS

Next year, two of the state's largest waivers expire: the 1915b waiver which provides SMHS through county mental health plans expires June 30, 2020, and the Medi-Cal 1115 waiver expires in December 31, 2020. There have been changes at the federal level in how budget neutrality is calculated. In many cases, states will not be able to demonstrate budget neutrality to draw down additional funding and this applies to California. Over the past several months, we have been looking at ways to preserve and protect core programs as well as laying a strong base for Medi-Cal to improve and innovate for the future. We plan to begin stakeholder meetings in Fall 2019 based on a waiver concept document to propose ideas. We expect there will be a need for small workgroups to discuss individual elements of the concept as well as input from this group.

Some current programs will remain in a waiver, such as the Global Payment Program. There are other initiatives such as Whole Person Care (WPC), PRIME, and the Dental Transformation Initiative (DTI) in which we need to identify different authorities and find ways to maximize funds. The 1915b waiver expires six months ahead of the 1115 and we are discussing a six-month extension with the federal government so that both would expire at the end of 2020. We will want to discuss with this group topics such as the IMD waiver for individuals with Serious Mental Illness or Serious Emotional Disturbance. There is a federal document on the IMD exclusion option. It describes a rigorous set of standards a state must meet to receive federal matching funds. It seems indicative that no other state has applied. We are interested in this and know it is an important topic that we will want to discuss. In addition, there are items county programs want to propose for discussion and we have a list at DHCS. We will share high-level thoughts in the fall to begin this discussion.

Questions and Comments

Jessica Cruz, NAMI California: Can you clarify the IMD conversation – are you looking at how the state can meet the requirements?

Jennifer Kent, DHCS: That is a big, broad topic and we haven't started the detailed conversation. The FAQ is useful to review. For example, we will need a maintenance of effort for expenditures. Will we need that for every county? Is this mandatory or voluntary? They will only provide federal funds if the average length of stay in an IMD is 30 days; they want an assessment of existing services including crisis stabilization; they want a plan for HIE, an implementation plan, quarterly reports and more. We, as a state, will have to decide if the funding opportunity is worth the additional requirements. I anticipate a workgroup on that topic to explore this in detail.

Stephanie Welch, Department of Corrections and Rehabilitation: We are tracking a New York state waiver tying Medicaid funding to jail populations specifically for those who would quality for a WPC-type model to do assessments to move those who are not a public safety threat out of jail. And, to bring providers in pre-release to offer services before discharge.

Jennifer Kent, DHCS: We are looking to preserve WPC. The Governor put new GF money into WPC, and we believe the program is valuable. There are certain populations within WPC, like those being released from incarceration, who are vulnerable and need health support services and housing to reenter successfully. We will try to protect that with new mechanisms and authorities.

Steve Fields, Progress Foundation: There are many concerns about opening IMD. Many counties do not have alternative systems for community services. I'm glad CMS will be rigorous on this. We need to think carefully about whether to go back to an IMD model. In the past, there were difficulties with how skilled nursing facilities billed. Another topic I want to introduce is workforce. How creative can we be in addressing the needs for workforce? Who is reimbursed also drives the system. We need to break out of the

paradigm of a credentialed system to move to a new era with noncredentialled who are more effective. We need a more diverse workforce ready to serve co-occurring disorders.

John Connolly, Los Angeles County Department of Public Health: The opportunity with the ODS waiver is unprecedented and we are looking to carry that forward in the next waiver. One thing to add in the renewal is an investment on the SUD workforce. While other sectors need to develop an unlicensed workforce, in SUD, we need an infusion of a greater licensed workforce. We need to think through the infrastructure as well and that should be a central part of the next waiver.

Catherine Blakemore, Disability Rights California: I want us to think broadly. The system remains fragmented. State hospitals have a lot of cost associated with them and still have people who could live successfully in community if services were there to support them. What money is going to county jails for mental health services for those who could be better served in community. I want us to think other systems and how money could be better used.

Veronica Kelley, San Bernardino County: We need to look at what we actually do currently and ask counties to speak to this. Behavioral health is doing much more that goes beyond mandates. We are asking clients what they need; leveraging different resources in MHSA and block grants and more. We see them all as our clients.

Kim Lewis, National Health Law Program: I am also interested in expanding the discussion. There has been a lot of change since realignment that changes the analysis. Now, 80% are in managed care and its expansions; children moved from CHIP to Medi-Cal, we have essential benefits requirements of MH, and the ODS/SUD waiver. I am not asking to open up realignment, but this is a different time and we need to add all of that to the history of realignment. Integration works and the current fragmentation doesn't work.

Michelle Cabrera, County Behavioral Health Directors Association of California: Counties are not providing solely medical model programs. Psychosocial aspects require we work across education, social services, jail services and more. We need a conversation of provider-level integration; to evolve the system to serve the whole needs of the person; and all populations, without the restrictions and screening out of certain individuals that happens currently. We need to spend time on the cultural, regulatory and financial barriers as well as gaps in the system. We need to invest in the system, so the substance use disorder, mental health and diabetes needs are met; so that sex offenders are not screened out. I want us to be cautious about moving too far to a medical model because it may not be the most effective way to serve folks.

Sarah Arnquist, Beacon Health Options: I want to add in a request for those with intellectual disabilities and co-occurring mental health or substance use. We see so much overlap, but they remain separate. Others are moving to discussions of global risk for these systems.

Jennifer Kent, DHCS: We are having internal conversation with other departments, including the Department of Social Services, Developmental Services and Public Health. Some with developmental disabilities may or may not be in the Medi-Cal system. The regional centers are important to bring to this discussion. There is a lot of complexity and we need more dialogue before bringing it here, but it is a good conversation to think through.

Chris Stoner-Mertz, California Alliance of Child and Family Services: We need to define success, so we know whether we are making progress. What are the outcomes we are looking to measure?

Jonathan Porteus, WellSpace Health: This is a great discussion of funding and it can become the tail wagging the dog. We need to define the continuum and identify the funding for that. It is exciting to think that we can get data to identify. We see meth as an ongoing problem and need to understand the most resource intensive issues we face. We do need to deal with co-occurring conditions, including behavioral health interaction with physical health.

Sara Gavin, CommuniCare Health Centers: There is tremendous work to be done and it needs to be done in partnership. Every county does things differently. Is there analysis of financial outcomes or access information across the counties? In particular, to compare counties that contract out and those that provide services directly.

Jennifer Kent, DHCS: I don't know that we have that on the mental health side. We have recent data on the SUD/ODS that includes fiscal data and the impact of federal funds on different modalities.

Farrah McDaid Ting, California State Association of Counties: Each county has local flexibility based on how realignment is designed and local needs. We are seeing a trend toward used space be contracted for crisis stabilization units or other mental health services.

John Connolly, Los Angeles County Department of Public Health: We have been intentional in LA about leveraging federal dollars to buy residential beds. We are at the limit of that strategy and have purchased all the certified beds available. We need investment infrastructure and more workforce, with lived experience and licensed staff, to expand.

Public Comment

Anna Hasselblad, United Ways of CA: I am heartened by the groups around the table and the discussion. I want to highlight that child-facing systems are a place with the greatest potential for shifting service design and improving long-term outcomes in adulthood. All conversations should include: What does this mean for kids and youth? How can we support youth with their unique entitlements? How do we encourage prevention?

Stuart Buttlaire, Kaiser Permanente: This is an enormous opportunity. What is the state's role vis a vis the counties especially where there is great variability, such as LPS? What is your role with each other and with the private sector?

Robert Harris, SEIU CA: This is an interesting discussion on many fronts. I haven't heard enough about the people who do the work – in clinics, schools, counties. We have licensed people as well as peers. SEIU would like additional consideration to include workers in this group. Workers voices need to be included. We are talking to schools and teachers about how to integrate services and reach people at the earliest stages.

Steve Leyoni, Consumer and Advocate: I have been coming to these meetings for 25 years. I am bothered that there is no designated consumer here. We are experts to consult with and it is useful to have us weigh in – for example, was the money wisely spent?

Carol Hood, Mental Health America: We want the committee to consider both process and content when making recommendations. California has been a leader in the meaningful inclusion of diverse clients and family in planning, implementation and evaluation of services and we need to ensure that the next steps expand on that history. We urge you to keep the client and family experience at the core of what we design. Respond to the mantra, "nothing about us without us."

Teresa Pasquini, Local, State and National Advocate: I want to add data from the soul. I am the proud mom of someone with mental illness. He benefitted from treatment, graduated from high school and had a job. When he reached adulthood and transitioned into that system, he fell off a cliff. I spend all of my time advocating for a full continuum of care so he will have a place to live when I am no longer here. I am following up on the February SAC meeting to urge an application for IMD for those who can't survive in supportive independent living. Please remove the lines in our health system and work together to design a system so everyone can live free and safe in optimal health.

Tamara Jimenez, Anaheim Lighthouse Residential Detox: Thank you all for the time you are putting in here. Unfortunately, we are a county where the Board of Supervisors is not spending their money on services. I'm hoping this committee will have a strong voice on parity. The parity laws are not enforced in California, especially in private insurance.

Next Steps and Final Comments

The October 29, 2019 meeting will be at 9:30 AM.

Jim Kooler, California Friday Night Live Partnership: There has been good work going on in the other committees that were folded in here. How do we capture that work and incorporate it into this group going forward?

Jennifer Kent, DHCS: Great question. We are looking to keep that work moving and integrate it here. When the request for agenda items comes to you, please suggest items, discussions and topics from your experience that you think are important. We look to you to suggest, and in some cases, lead discussions on those items.

Alex Dodd, Aegis Treatment Centers: Thank you to the speakers. There is a big role for the state to ensure counties keep their side of the bargain. We work with 36 counties who try to deliver good care and there is great variation we can learn from.